

DR. BALLIN

1 CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 24 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) 60 MEMORIAL HOSPITAL				d. STREET ADDRESS 44 N. MECHANIC STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARGUERITE Middle S. Last ALLEN				4. DATE OF DEATH Month JANUARY Day 25 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 1 1910	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Notion Store		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME C. GLENN WATSON				14. MOTHER'S MAIDEN NAME ETHEL SWANGER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 10 8841		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancreatitis, acute 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1 , 19 57 , to 1-25 , 19 57 , that I last saw the deceased alive on 1-24 , 19 57 , and that death occurred at 12:01 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. Cumberland Md. DATE SIGNED 1-25-57							
ACTUAL SIGNATURE Regis W. Ballin M.D.							
PHYSICIAN'S NAME (Type) DR. BALLIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 27 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Right				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 26, 1957	
				24b. REGISTRAR'S SIGNATURE W. H. Right, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
JAN 29 1957
BUREAU V. 3

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 39 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at-Sacred Heart Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rose Middle G. Last Allison				4. DATE OF DEATH Month Jan. Day 18 Year 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 22-1892		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Johnstown, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fredrick Myers				14. MOTHER'S MAIDEN NAME Jennie Nelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address (husband) Jacob H. Allison, Flintstone, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 260x DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (b) Diabetes mellitus (c) Diabetes mellitus DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH sudden 4 or 5 Yrs. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H.V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 18-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Cumberland, Maryland				24a. REC'D BY REGISTRAR Jan 21 1957 24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 23 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>10 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>				d. STREET ADDRESS <u>E. Main St. Gerson Apt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Anderson</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1887</u>		9. AGE (In years last birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months <u>69</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Garrett Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mark Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Fazenbaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W.W.1 217-03-6413</u>		17. INFORMANT Address <u>Miners Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>523.0 Broncho pneumonia with lung abscesses</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>903.5</u> (b) <u>Silicosis (bilateral) marked.</u> DUE TO (c) <u>Emaciation (marked)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric fracture of left femur</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on sidewalk</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> o. m. <u>Nov. 7</u> 19 <u>56</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Sidewalk</u>		20f. (City or town) (County) (State) <u>Frostburg Allegany Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 21-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Hurst</u>				24a. REC'D BY REGISTRAR <u>DATE 1-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nellie H. Roe</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF ILLINOIS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 1 1957

RECEIVED

71 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>			d. STREET ADDRESS <u>14 Washington St.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14 Washington St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Nolan</u> Last <u>Bahen</u>			4. DATE OF DEATH Month <u>I</u> Day <u>8</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25th. 1881</u>		9. AGE (In years lost birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Peter Nolan</u>			14. MOTHER'S MAIDEN NAME <u>Johanna Collins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			17. INFORMANT <u>Martin Bahen, Son, 14 Washington St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>447X Arterio sclerosis - Hypertension</u> DUE TO (b) <u>Serial</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Serial years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>Jan 8</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 7</u> , 19 <u>57</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>WOMC Lane</u> M.D.			ADDRESS (Street, city or town, state) <u>Frostburg Md.</u>		
PHYSICIAN'S NAME (Type) <u>WOMC Lane MD</u>			DATE SIGNED <u>1-10-57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>I-II-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cem.</u>	22d. LOCATION (City, town, or county) <u>Frostburg</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Burial H. Montanari</u> ADDRESS <u>Hafer Funeral Home 23 E. Main, Frostburg, Md.</u>			24a. REC'D BY REGISTRAR <u>DATE 1-12-57</u>	24b. REGISTRAR'S SIGNATURE <u>Dan Jimmy N. Re</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

WESTERN STATE DEPARTMENT OF HEALTH - BUREAU ONE 18

BUREAU Y. S.

JAN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 53 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Sacred Heart Hospital			d. STREET ADDRESS 1114 W. First St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Anthony Last Beck			4. DATE OF DEATH Month Jan. Day 3 Year 1957		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1-1903		9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Spa Bar	11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony Beck			14. MOTHER'S MAIDEN NAME Mary Young		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-4362	17. INFORMANT (wife) Evelyn D. Beck, Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Myocardial infarction DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH sudden 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H. V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 3-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF I-7-57	22c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 7, 1957	
				24b. REGISTRAR'S SIGNATURE C. R. Frantz, M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 9 1937
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

72 CERTIFICATE OF DEATH

00006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Id. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Postburg		c. LENGTH OF STAY IN 1b 8 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bruce Middle Boal Last Boal		4. DATE OF DEATH Jan 17 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Mar. 1906
9. AGE (In years last birthday) yrs 50		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Barton, Id.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Boal.		14. MOTHER'S MAIDEN NAME Sydney Katherine Boal Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 214-07-3269	
17. INFORMANT Mrs. Robert Kelly-Barton, Id.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 17, 1957 to January 17, 1957 that I last saw the deceased alive on January 17, 1957 , and that death occurred at 6:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Union Hall 67 Main St Westernport, Maryland DATE SIGNED			
ACTUAL SIGNATURE Medard E. Hoesley M.D.		PHYSICIAN'S NAME (Type) Westernport, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/19/57	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem.	22d. LOCATION (City, town, or county) (State) Id.
23. FUNERAL DIRECTOR'S SIGNATURE Ed. H. H. H.		ADDRESS Westernport, Id.	
24a. REC'D BY REGISTRAR 1-20-57		24b. REGISTRAR'S SIGNATURE Mr. Nancy H. Roe	

BUREAU V. S.

RECEIVED

73

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 7 Lonaconing d. STREET ADDRESS East Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick T. Bowden		4. DATE OF DEATH January 30 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 2, 1878	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor		10b. KIND OF BUSINESS OR INDUSTRY Presbyterian		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Bowden		14. MOTHER'S MAIDEN NAME Louise Nightingale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 215-16-4531		17. INFORMANT Charles Bowden "Son" Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443 X Congestive Heart Failure DUE TO (b) Hypertension, essential DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Sensitivity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 19 56 to Jan 29 19 57 , and that death occurred at 2 57 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.		Lonaconing, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Lonaconing Md.		24a. REC'D BY REGISTRAR 2-1-57		24b. REGISTRAR'S SIGNATURE Miss Nancy N. De	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 5 1957

BUREAU V. L.

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Hampshire</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>5 months</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>502 N. Mechanic St.</u>			d. STREET ADDRESS <u>95X 3 Rural</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN C. BOWMAN</u>			4. DATE OF DEATH Month Day Year <u>Jan. 4, 19 57</u>		
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 1 1971</u>		9. AGE (In years last birthday) <u>85</u> yrs.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>
13. FATHER'S NAME <u>Ceylon Bowman</u>			14. MOTHER'S MAIDEN NAME <u>Martha See</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>One</u>	17. INFORMANT Address <u>Mrs. Herman Bowman, Cumberland, Md.</u>		
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Ischemia</u> <u>Hx</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic heart disease, generalized</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>June 1956</u> to <u>1/4 1957</u> , that I last saw the deceased alive on <u>1/2 1957</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>456 N. Centre St</u>		DATE SIGNED <u>1/5/57</u>	
PHYSICIAN'S NAME (Type) <u>L. C. H. L. Y. JR.</u>		<u>Cumberland Ind.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/7/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rio Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rio, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Vade McKee</u>		ADDRESS <u>Augusta, W. Va.</u>		24a. REC'D BY REGISTRAR <u>Jan 7, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

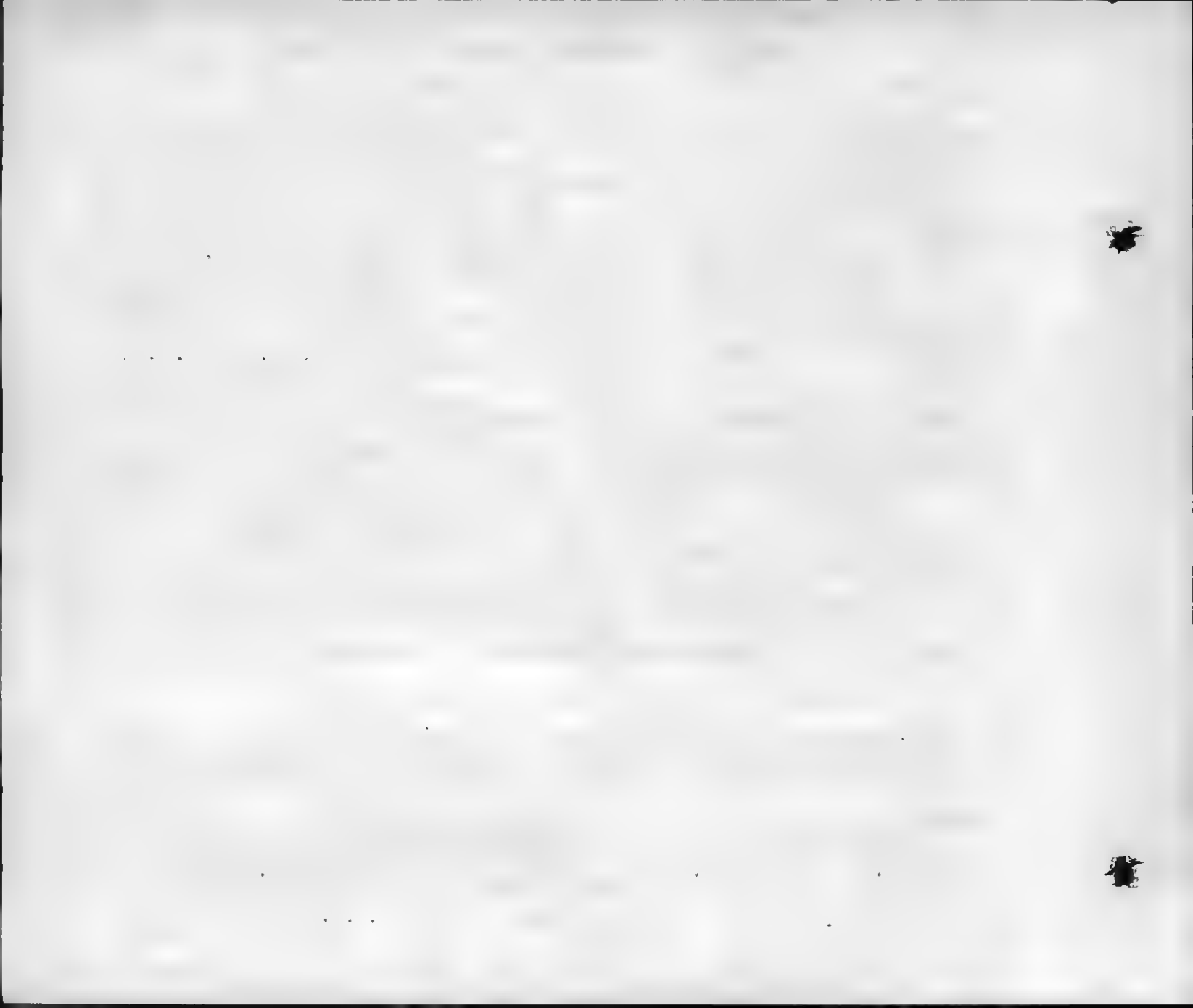
00009

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Edward</u> Last <u>Bowman</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>6</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1-1896</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Consolidated Engineering-Old Fields, W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Silas Bowman</u>		14. MOTHER'S MAIDEN NAME <u>Ruhamia Shears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-03-8746</u>	
17. INFORMANT <u>Memorial Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis (bilateral)</u> DUE TO <u>Ruptured left lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fractured ribs (left side of chest)</u> DUE TO <u>Hemothorax-left-</u> (c) <u>Crushed chest (left)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Chest crushed between truck and building.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Chest crushed between truck and building.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:30</u> a. m. <u>1-4</u> <u>1957</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pitt P & G Co.</u>		20f. (City or town) (County) (State) <u>North Branch, Allegany Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 7-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 9, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>R.F.D. #1, Cumberland, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Jan. 8, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank M.D.</u>	

1. DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Within corporate limits

6

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle F Last BRANT				4. DATE OF DEATH Month JANUARY Day 5 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 12, 1910	
9. AGE (In years lost birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) MARYLAND, Dawson	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL E. DAWSON				14. MOTHER'S MAIDEN NAME EMMA MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-14-5352		17. INFORMANT Robert B. Brant, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Thrombosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from Jan. 7, 1957 , to Jan. 7, 1957 , that I last saw the deceased alive on Jan. 7, 1957 , and that death occurred at 6:50 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED Jan. 7, 1957							
ACTUAL SIGNATURE James G. Stegmaier, M.D. M.D. 12-8-57							
PHYSICIAN'S NAME (Type) James G. Stegmaier, M.D.							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Jan. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24. REC'D BY REGISTRAR Jan. 7, 1957		24b. REGISTRAR'S SIGNATURE W. H. Brant, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 9 1957

RECEIVED

BUREAU V. S.

JAN

1910

Within corporate limits

DR. WEISMAN

8

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL-MEMORIAL & WARWICK AVES.		d. STREET ADDRESS 11 ARCH STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SYLVESTER Middle J Last CLARK		4. DATE OF DEATH Month JAN. Day 4 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 9, 1887 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired machinist		10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.	
11. BIRTHPLACE (State or foreign country) MARYLAND Westernport		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH H. CLARK		14. MOTHER'S MAIDEN NAME ELIZABETH TREVER Treiber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL-CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) Coronary Sclerosis + Insufficiency (c) Arteriosclerosis + Anemia		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized malnutrition of skeleton, possibly multiple		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stroke	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 11 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 19 56 to Jan 4, 19 57 , that I last saw the deceased alive on Jan 4, 19 57 , and that death occurred at 6:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Greene St Cumberland Maryland DATE SIGNED 1/5-15-7			
ACTUAL SIGNATURE A. Weissman M.D.		PHYSICIAN'S NAME (Type) 59 WEISMAN MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/7/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Jan 7, 19 57		24b. REGISTRAR'S SIGNATURE W. R. Frank M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 9 1907

RECEIVED

DR. LEY

9

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN lb 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS Miller Farm			
3. NAME OF DECEASED (Type or print) First HARVEY Middle COLEMAN Last				4. DATE OF DEATH Month JANUARY Day 12 Year 57			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 11 1885	9. AGE (In years lost birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY Farmhand		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME GEORGE W. COLEMAN				14. MOTHER'S MAIDEN NAME ISABEL SHULER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 233-09-0238		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 1/4 , 19 57 , to 1/12 , 19 57 , that I last saw the deceased alive on 1/11 , 19 57 , and that death occurred at 6:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo N. Ley, Jr.				ADDRESS (Street, city or town, state) 456 N. Centre St.		DATE SIGNED 1/14/57	
PHYSICIAN'S NAME (Type) DR. LEO LEY				Cumberland Ind.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORY Pope Cem		22d. LOCATION (City, town, or county) (State) Ridgeley W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR Jan 14, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Harty M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 18 1907

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Florida</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jacksonville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>341 Columbia Ave.</u>				d. STREET ADDRESS <u>303 S. McDuff Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ora</u> Middle <u>Ola</u> Last <u>Conner</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>22</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6-1888</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. of the Tropical Glass Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Elk Garden, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		
13. FATHER'S NAME <u>George W. Conner</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Jane Sowers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>322-10-8855</u>		17. INFORMANT <u>(brother) Vernon Conner, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 22-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 25, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Madley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Madley, Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kight Funeral Home, Frostburg, Maryland.</u>		ADDRESS		24a. REC'D BY REGISTRAR <u>Jan. 24, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>H. V. Deming M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any amendment within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00015

11

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3hrs. 45 mi.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital, Memorial Ave.			d. STREET ADDRESS 1019 Virginia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mr. Irvin H. Crabtree			4. DATE OF DEATH Month Jan. Day 20 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1903		9. AGE (in years last birthday) 53 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Inspector		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Crabtree			14. MOTHER'S MAIDEN NAME Virginia Thomas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-05-9375		17. INFORMANT Address Memorial Hospital, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Coronary Occlusion DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to Jan , 19 57 , that I last saw the deceased alive on Jan 20 , 19 57 , and that death occurred at 7:15 PM from the causes and on the date stated above.					
ACTUAL SIGNATURE G. Overton Himmelwright, M.D.		ADDRESS (Street, city or town, state) 133 W. Ave., Cumberland, Md.		DATE SIGNED 1/22/57	
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		ADDRESS		24a. REC'D BY REGISTRAR JAN 22 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

BUREAU V. S.

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Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88

CERTIFICATE OF DEATH

00016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Winchester Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Delphia</u> Middle <u>May</u> Last <u>Cuff</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>16</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 27, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Grafton, W. Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>Henry Luzader</u>	
14. MOTHER'S MAIDEN NAME <u>Louisa Gelhausen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>Mr. Patrick Cuff Cresaptown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-4</u> <u>1954</u> , to <u>1-16-</u> <u>1957</u> , that I last saw the deceased alive on <u>1-14-</u> <u>1957</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>57 Greene St.,</u> DATE SIGNED <u>1/19/57</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Lewis Brings</u> PHYSICIAN'S NAME (Type) <u>Lewis Brings M. D.</u> <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/19/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Ambrose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cresaptown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> <u>Cumberland, Maryland</u>		24. REC'D BY REGISTRAR <u>19/19/57</u>	
24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00017

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Memorial Hospital		d. STREET ADDRESS State St.	
3. NAME OF DECEASED (Type or print) First Hannah Middle May Last Cutter		4. DATE OF DEATH Month Jan. Day 17 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7-1898
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 5 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Russell		14. MOTHER'S MAIDEN NAME Jean Russell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (husband) Walter Cutter, Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage (apoplexy) about 10 hrs. 831X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular sclerosis DUE TO (c) ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 18-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20, 1957	
22c. NAME OF CEMETERY OR CREMATORY Johnson Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.		24a. REC'D BY REGISTRAR Jan. 19, 1957	
24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN

RECEIVED

89

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Id.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin-rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Franklin-rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 mi N. Westernport</u>		e. STREET ADDRESS <u>1 mi N. Westernport</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Walter Dailey</u>		4. DATE OF DEATH Month Day Year <u>Jan 22 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1882</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper mill</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Michael Dailey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Morgon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>216-10-1444</u>	
17. INFORMANT <u>John T. Dailey-Isabella, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis and Myocardial Degeneration Not Specified As Rheumatic</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 Years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 Years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 8</u> , 1957, to <u>Jan. 22</u> , 1957, that I last saw the deceased alive on <u>Jan 21</u> , 1957, and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Paul B. Wilson</u> M.D. <u>Piedmont, W. Va.</u> <u>Jan 24 1957</u> PHYSICIAN'S NAME (Type) <u>Paul R. Wilson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/24/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport Id.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. B. B. B.</u>		24a. REC'D BY REGISTRAR <u>DATE 1-24-57</u>	
24b. REGISTRAR'S SIGNATURE <u>John C. Kelly</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

RECEIVED
JAN 28 1957
BUREAU V. S.

25 JAN 25 25
H V

JAN 8

25 JAN 31
Campbell

90 CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ALLEGANY</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>ALLEGANY</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>ELLSBURG</u>	<u>LIFE</u>	TOWN <u>ELLSBURG</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>DAVID DEWE</u>		<u>JAN. 22 1957</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>JAN. 1, 1973</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>LABORER</u>		<u>FURNITURE</u>	<u>ELLSBURG, MD</u>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<u>Wm. T. Dewe</u>		<u>DIABHRA E. WIT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
<u>NO</u>		<u>Wm. T. Dewe, Ellensburg, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Chronic Myocardosis</u>			<u>10 yrs</u>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST, DUE TO			
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 22</u> , 19 <u>57</u> , to <u>Jan 22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 22</u> , 19 <u>57</u> , and that death occurred at <u>11:45</u> A.M., from the causes and on the date stated above.			
SIGNATURE <u>John A. Jopper</u> M.D.		ADDRESS (Street, city, town, state) <u>Hydman, Pa.</u>	
DATE SIGNED <u>1/23/57</u>		DATE SIGNED <u>1/23/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>JAN 24 1957</u>	<u>LEATON CEMETERY</u>	<u>ALLEGANY CO. PA.</u>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE <u>1/24/57</u>	<u>Lloyd Wolfe</u>	<u>Henry H. Zapp</u>	<u>Hydman, Pa.</u>

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

JUN 1957

RECEIVED

13

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allogany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allogany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 12/4/56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allogany County Infirmary				d. STREET ADDRESS 519 Bedford Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Dicken				4. DATE OF DEATH Month January Day 5 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1861		9. AGE (In years last birthday) 95 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Isaac Leasure				14. MOTHER'S MAIDEN NAME Martha Pennal			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 1-1-0			
17. INFORMANT P. O. Box 599 Address Cumberland, Md. Allogany County Infirmary Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 DUE TO Pulmonary Hypertension Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) Chronic Myocarditis Cerebral Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/4/56 , 19____, to 1/5/57 , 19____, that I last saw the deceased alive on 1/5/57 , 19____, and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 1/5/57							
ACTUAL SIGNATURE James E. McLean M.D.				PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Jan 7 1957		22c. NAME OF CEMETERY OR CREMATORY Le Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 7 1957 24b. REGISTRAR'S SIGNATURE W. H. Kight M.D.	

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00021

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corrigansville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at the Memorial Hospital</u>		d. STREET ADDRESS <u>Corrigansville</u>	
3. NAME OF DECEASED (Type or print) First <u>Ellen</u> Middle <u>Marie</u> Last <u>Drumm</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>15</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1-1956</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Kenneth J. Drumm</u>		14. MOTHER'S MAIDEN NAME <u>Gustava Meyers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>(father) Kenneth J. Drumm</u>		Address <u>Md. - Corrigansville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>7219</u> DUE TO <u>Aspiration of stomach contents.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 15-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 17, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter & Paul</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Allegany Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		24a. REC'D BY REGISTRAR <u>Jan. 17, 1957</u>	
ADDRESS <u>Cumberland, Md</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of time of death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

RECEIVED
AN 21 1957
BUREAU V. S.

74

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
				d. STREET ADDRESS Allegany Street			
3. NAME OF DECEASED (Type or print) First Howard Middle Duckworth Last				4. DATE OF DEATH Month 1/23/1957 Day 19 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/2/1885	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Wva. Pulp & Paper CO.				10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, MD.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Simeon Duckworth				14. MOTHER'S MAIDEN NAME Margaret Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 216-05-9623			
17. INFORMANT Mrs. Sarah Duckworth, Lonaconing, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bronchial asthma DUE TO (c) Hypertension - Essential				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 434.1				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8-17-56 , 19 56 , to 1-23-56 , 19 56 , that I last saw the deceased alive on 1-23-56 , 19 56 , and that death occurred at 4:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Gertrude R. Miles M.D.							
FURNITURE NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.				24a. REC'D BY REGISTRAR DATE 1-28-57		24b. REGISTRAR'S SIGNATURE Miss Nancy N. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1977

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

75

CERTIFICATE OF DEATH

00023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admittance) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 1 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kookan Nurseing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Abram First P. Middle Dunn Last		4. DATE OF DEATH January Month 30 Day 19 57 Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1878
9. AGE (In years lost birthday) 78 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Dunn		14. MOTHER'S MAIDEN NAME Janet Peebles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wm Cuthbertson Address Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio renal Disease. 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arteriosclerosis. (c) bronchial asthma.		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 15, 19 56 to Jan 30, 1957 , that I last saw the deceased alive on Jan 23, 19 57 , and that death occurred at 6 PM , from the causes and on the date stated above.			
ADDRESS (street, city or town, state) Piedmont, Va.		DATE SIGNED 20 Jan 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/57	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR 2-4-57	
ADDRESS Lonaconing, Md.		24b. REGISTRAR'S SIGNATURE John C Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1937

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00024

DR. WHITWORTH:

15

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY Ledford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN			
c. LENGTH OF STAY IN 1b 4 DAYS				d. STREET ADDRESS RT. #1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BABY Middle GIRL Last EMERICK				4. DATE OF DEATH Month JANUARY Day 8 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 4, 1957	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME KENNETH M. EMERICK				14. MOTHER'S MAIDEN NAME BETTY LOU KENNARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL—CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.2 Congenital Heart (3 chamber) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Interventricular Septum DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:35A , from the causes and on the date stated above.							
ACTUAL SIGNATURE Fuller B. Whitworth, M.D.				ADDRESS (Street, city or town, state) Bedford Co. Pa.			
PHYSICIAN'S NAME (Type) Fuller B. Whitworth, M.D.				DATE SIGNED Jan 10 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 10, 1957		Falso Otto Cemetery Hyndman, Bedford Co. Pa.		Bedford Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE James P. Leigh				ADDRESS Hyndman, Pa.		24b. REGISTRAR'S SIGNATURE W.D. Frantz, M.D.	

RECEIVED

1957

RECEIVED

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS 519 City View Terrace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 519 City View Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Pauline Elizabeth Fayman		4. DATE OF DEATH Month Day Year January 18, 19 57	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1911
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Vernon Graves		14. MOTHER'S MAIDEN NAME Caroline Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Jack A. Fayman, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ovary, bilateral, with generalized abdominal metastasis. DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Approximately 3 years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 17, 1955 to January 17, 1957 , that I last saw the deceased alive on January 17, 1957 , and that death occurred at 3:35 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Washington Street DATE SIGNED Jan 19, 1957			
ACTUAL SIGNATURE W. M. Faw, Jr.		PHYSICIAN'S NAME (Type) Dr. W. M. Faw, Jr.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 22, 1957	
		24b. REGISTRAR'S SIGNATURE W. R. Grant, M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.
1957

76

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 22 mos.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital			d. STREET ADDRESS 1		
3. NAME OF DECEASED (Type or print) First MARY JANE Middle L. Last FOLK			4. DATE OF DEATH Month Jan. Day 23 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1864		9. AGE (In years last birthday) 92 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Mose Folk			14. MOTHER'S MAIDEN NAME Anna Madden		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Emma Izzett, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic Heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 2 days - years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan. 23, 1957 to Jan. 23, 1957 that I last saw the deceased alive on Jan 23, 19 57 and that death occurred at 4:15 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE John B. Davis, M.D.			DATE SIGNED 2 Broadway Frostburg Md 1/23/57		
PHYSICIAN'S NAME (Type) John B. DAVIS, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-25-57		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery	
22d. LOCATION (City, town, or county) Mt. Savage, Md.		22e. (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.			24a. REC'D BY REGISTRAR DATE 1-25-57		
			24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe		

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 1 1957

BUREAU V. S.

17

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1 PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY in 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hosp.</u>				d. STREET ADDRESS <u>639 Schriver Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>H.</u> Middle <u>Fradiska</u> Last				4. DATE OF DEATH <u>Jan 26</u> Month <u>Jan</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 23, 1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Brewmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Duman Brewery</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Fradiska</u>				14. MOTHER'S MAIDEN NAME <u>Anna Beck</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-4992</u>		17. INFORMANT <u>Mrs. Anna Fradiska</u> Address <u>Cumb. Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							<u>2 days</u>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 24</u> , 19 <u>57</u> , to <u>Jan 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 26</u> , 19 <u>57</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Jr</u>				ADDRESS (Street, city or town, state) <u>220 Baltimore Ave, Cumberland, Md</u>			
DATE SIGNED <u>1/28/57</u>							
PHYSICIAN'S NAME (Type) <u>R. W. Trevaskis, Sr</u>				220 Baltimore Ave, Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>1/29/57</u>		<u>Hillcrest Cem.</u>		<u>Cumberland Md.</u>	
23 FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumberland Md</u>		24a. REC'D BY REGISTRAR <u>Jan 28, 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. H. Frantz, Md</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 1 1907

RECEIVED

Within corporate limits

18

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6/1/56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			d. STREET ADDRESS 126 Columbia Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Jennie Middle H. Last Gardner			4. DATE OF DEATH Month January Day 12 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/1879		9. AGE (In years last birthday) 77 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker and Retired Mgr., Hotel		10b. KIND OF BUSINESS OR INDUSTRY Lockport, Pennsylvania		11. BIRTHPLACE (State or foreign country) U. S. A.	
13. FATHER'S NAME James Gardner			14. MOTHER'S MAIDEN NAME Charlotte A. Marbourg		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Central Hemorrhage DUE TO Central Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Right Heart Failure					INTERVAL BETWEEN ONSET AND DEATH 1 yr + ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right Heart Failure					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/1/56 , 19 1/12/ , 1957, that I last saw the deceased alive on 1/12/57 , 19 12 , and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 1/14/57					
ACTUAL SIGNATURE James E. McLean M.D.		PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE William H. Knight		ADDRESS Cumberland Md		24a. REC'D BY REGISTRAR Jan 15, 1957	
24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 12 1917

RECEIVED

19

CERTIFICATE OF DEATH

Reg. Dist. No.

00029

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 2 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, MEMORIAL AVE.				e. STREET ADDRESS 224 GRAND AVE.			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last GARLITZ				4. DATE OF DEATH Month JAN. Day 24 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/24/57	
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME GILBERT GARLITZ				14. MOTHER'S MAIDEN NAME JULIA FADLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE B. M. Schindler M.D. 41 Brewitt 1/25/57 PHYSICIAN'S NAME (Type) B. M. SCHINDLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Jan. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Memorial Hospital Cumberland, Md.				24. REC'D BY REGISTRAR Jan. 26, 1957			
24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2.

1967

1

RECEIVED

Within corporate limits

DR. VAN ORMER

20

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL & WARWICK AVE.				d. STREET ADDRESS ADVOCATE COURT			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last GORMAN E GETTY				4. DATE OF DEATH Month Day Year JANUARY 14 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 23, 1888	
9. AGE (In years last birthday) 68 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Dentist - Self		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILLIAM O. GETTY				14. MOTHER'S MAIDEN NAME ALICE KELLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL-CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage, Recurrent, DUE TO Cerebral Hemorrhage, with left Hemiplegia, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs 1950			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 13 Jan., 1957 , to 14 Jan., 1957 , that I last saw the deceased alive on 14 Jan., 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 15 Jan. 57							
ACTUAL SIGNATURE W. A. Van Ormer M.D.							
PHYSICIAN'S NAME (Type) DR. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/17/1957		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				ADDRESS LONACONING? MD.		24a. REC'D BY REGISTRAR JAN 17 1957	
				24b. REGISTRAR'S SIGNATURE W. H. Frantz, M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AN 21 1957

BUREAU V. I.

RECEIVED

JAN 2 1957

BUREAU V. S.

91

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 91 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Charlestown Street		e. STREET ADDRESS Charlestown Street	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH January 5 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1865
9. AGE (In years lost birthday) 91 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert T. Grove		14. MOTHER'S MAIDEN NAME Catherine Dye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO	
17. INFORMANT Robert M. Grove		Address Lonaconing, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days many yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 56 , to Jan , 19 57 , that I last saw the deceased alive on Jan 4 , 19 57 , and that death occurred at 3 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/8/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 1-9-57	24b. REGISTRAR'S SIGNATURE Janette M. Goad

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 11 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		00033	
DR. B. SCHINDLER		21	
CERTIFICATE OF DEATH		Reg. Dist. No. 4	
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admision) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 18 DAYS		d. STREET ADDRESS 718 WASHINGTON STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MADELINE Middle GUGGENHEIMER Last IMMER		4. DATE OF DEATH Month JANUARY Day 31 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1898
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 3 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Sect. Treas.		10b. KIND OF BUSINESS OR INDUSTRY Furniture Co.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LOUIS BERNSTEIN		14. MOTHER'S MAIDEN NAME SARAH GOLDENBERG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-5324	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon with metastases 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 31, 1945 to Jan 31, 1957 that I last saw the deceased alive on Jan 31, 1957 , and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. M. Schindler M.D.		DATE SIGNED 4/1 Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. BLAINE SCHINDLER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/3/57	
22c. NAME OF CEMETERY OR CREMATORY East View Cen.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR 661		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00034

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>46 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>City Jail</u>				d. STREET ADDRESS <u>66 Bowery St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>Olin</u> <u>Gunnnett</u>				4. DATE OF DEATH Month Day Year <u>Jan.</u> <u>24</u> <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4-1910</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Frostburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Olin Gunnnett</u>				14. MOTHER'S MAIDEN NAME <u>Annie Krause</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>236-12-8772</u>		17. INFORMANT Address <u>Brother-Harry M. Gunnnett, Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>322.1</u> DUE TO (b) <u>Chronic alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 25-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-27-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Deming</u>				24a. REC'D BY REGISTRAR DATE <u>1-27-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. Stanley H. Ritz</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

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RECEIVED

Within corporate limits

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Alle any</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived If institut an Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Imps id</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			d. STREET ADDRESS <u>85x 3</u> <u>Rural</u>		
3. NAME OF DECEASED (Type or print) First <u>Henderson</u> Middle <u>May</u> Last <u>Henderson</u>			4. DATE OF DEATH Month <u>January</u> Day <u>23</u> Year <u>1957</u>		
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-1900</u>		9. AGE (n years lost birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cum isue</u>	11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>George Hopson</u>			14. MOTHER'S MAIDEN NAME <u>Jennie Kline</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Patient's Chart</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with thrombocytopenia</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Two years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nodular Goiter</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>1-22-1957</u> to <u>1-23-1957</u> that I last saw the deceased alive on <u>1-22-1957</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James T. Johnson, Jr.</u>		ADDRESS (Street, city or town, state) <u>Cumberland, MD</u>			
PHYSICIAN'S NAME (Type) <u>James T. Johnson, Jr., M.D.</u>		DATE SIGNED <u>1-23-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>Jan 26 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Camp Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rich Jones</u>		ADDRESS <u>August, V.</u>		24a. REC'D BY REGISTRAR <u>Jan 24, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 25 1957

RECEIVED

79

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS Douglas Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Christopher First Middle Last Hendra		4. DATE OF DEATH January 8 1957 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1904
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman General Textile Mill		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Hendra		14. MOTHER'S MAIDEN NAME Janette Hausman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-2924	
17. INFORMANT Mrs. Margaret Hendra		Address "Wife"	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 42 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 6 1957 , to Jan 8 1957 , that I last saw the deceased alive on Jan 8 1957 , and that death occurred at 508 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway Lonaconing, MD. DATE SIGNED 1/9/57			
ACTUAL SIGNATURE Hilda Gurlibsky M.D.			
PHYSICIAN'S NAME (Type) Hilda Lane Walters M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	
24a. REC'D BY REGISTRAR DATE 1-11-57		24b. REGISTRAR'S SIGNATURE Miss Mary N. [Signature]	

TO HONORARY OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 22 1911

RECEIVED

Within corporate limits

23

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. c. LENGTH OF STAY IN 1b Cumberland Maryland d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 241 New Hampshire Ave.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Maryland d. STREET ADDRESS 241 New Hampshire Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Bernadette Hewitt First Middle Last				4. DATE OF DEATH Jan. 17 1957 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1882 yrs. 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Mathews				14. MOTHER'S MAIDEN NAME Johanna Dohaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Rev. Leo W. Hewitt, Cumberland, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concussion of the cranium (body) 172X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Signs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 3-2-1952 to 1-17-1957 , that I last saw the deceased alive on 1-14-1957 , and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE L. Brings M.D. St. Mary's P. Cumberland Md 1-18-57 PHYSICIAN'S NAME (Type) Lewis Brings							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-1957		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md. (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. ADDRESS _____				24a. REC'D BY REGISTRAR Jan 19, 1957		24b. REGISTRAR'S SIGNATURE W. K. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1911
BUREAU V. S.

00039

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 1 1/2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle J. Last HITCHINS		4. DATE OF DEATH Month Jan. Day 25 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-1889
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 67 Days 67 Hours 67 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Tri-State Mine & Mill Supply Co	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Owen E. Hitchins		14. MOTHER'S MAIDEN NAME Nancy Powell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 214-05-6718	
17. INFORMANT Mrs. Nancy Roe, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Emphysema DUE TO (c) Chronic right heart failure			
INTERVAL BETWEEN ONSET AND DEATH 30 sec. 15 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic right heart failure			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 9 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1952 to Jan. 25, 1957 , that I last saw the deceased alive on Jan. 25, 1957 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Martin M. Rothstein</i>		DATE SIGNED 1/26/57	
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-1957	
22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst		24a. REC'D BY REGISTRAR 1-28-57	
ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE <i>N. R. ...</i>	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, or other person authorized by the law, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00038

24

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 2 DAYS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		
f. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL			d. STREET ADDRESS 101 WASHINGTON STREET		
3. NAME OF DECEASED (Type or print) First MIDDLE Last IRVING T. HOLLAND			4. DATE OF DEATH Month JANUARY Day 17 Year 57		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 2, 1876	9. AGE (In years last birthday) 86 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Sales Operator Gas Station			10b. KIND OF BUSINESS OR INDUSTRY MISSOURI		
11. BIRTHPLACE (State or foreign country) MISSOURI			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY R. HOLLAND			14. MOTHER'S MAIDEN NAME SARAH BEALL		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Spanish Am.			16. SOCIAL SECURITY NO. —		
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio-sclerotic heart disease 2 years (c) Gen. arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 4 days ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1 p.m., 1955 to 17 p.m., 1957 that I last saw the deceased alive on 17 Jan. 1957, and that death occurred at 5:20 P.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE W. Alfred Van Ormer			ADDRESS (Street, city or town, state) Cumberland, Md.		
PHYSICIAN'S NAME (Type) W.A. VAN ORMER, M.D.			DATE SIGNED 18 Jan. 57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem		22d. LOCATION (City, town or county) (State) Cumberland Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.			ADDRESS Cumb Md		
24a. REC'D BY REGISTRAR Jan 19, 1957			24b. REGISTRAR'S SIGNATURE W.R. Freutz, M.D.		

RECEIVED
JAN 23 1957
BUREAU Y. S.

00040

92 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY	ALLEGANY		STATE	MARYLAND	
CITY (If outside corporate limits, write RURAL or end give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY		
TOWN	20 years	TOWN	CRESAPTOWN		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
L. A. U. A. (First) MAY (Middle) HILLER (Last)			JAN. 26 1957		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR
Female	WHITE	WIDOWED	Sept. 14, 1872	84 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		
House work			Housewife		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Belford, Pa. Penna.			U.S.A.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
WILLAS MAY			ELIZABETH MAY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, in, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			None		
17. INFORMANT & ADDRESS			18. MEDICAL CERTIFICATION		
Thomas Hiller, Cresaptown, Md.			I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Heart failure</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerosis, heart disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		
21f. HOW DID INJURY OCCUR?			22. I hereby certify that I attended the deceased from 1/20, 1950, to 1/26, 1957, that I last saw the deceased alive on 1/24, 1957, and that death occurred at 55 Queen St. M.D. 1/28/57		
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE SIGNED		
Burial			1/28/57		
DATE THEREOF			NAME OF CEMETERY OR CREMATORY		
Jan 28, 1957			Cresaptown, Md.		
24. REC'D BY REGISTRAR			25. FUNERAL DIRECTOR'S SIGNATURE		
28-28, 1957			Walter R. Trout, M.D.		

1. INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. At this time, the funeral director, in the presence of the registrar, shall file the death certificate and the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

UNITED STATES

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RECEIVED

CERTIFICATE OF DEATH

00041

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>6y. 11mo. 6da.</u>		TOWN <u>Barton</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat, Furnace St.</u>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>John J Howell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 20 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>9-9-1876</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mines</u>	11. BIRTHPLACE (State or foreign country) <u>Barton, Maryland.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jefferson Howell</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-03-5976</u>		17. INFORMANT & ADDRESS <u>121 Bowery Mrs. Ralph Steele Frostburg daughter</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pulmonary Hypostasis</u>				<u>48 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Severe Arteriosclerosis</u>				<u>?</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Severe psychosis</u>				<u>6 yrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 19, 1957</u> to <u>Jan. 21, 1957</u> , that I last saw the deceased alive on <u>Jan. 19, 1957</u> , and that death occurred at <u>11:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James B. Drake</u> M.D.				DATE SIGNED <u>49 Spruce St. Frostburg Md. 1-21-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-23-57</u>		NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		LOCATION (City, town, of county) (State) <u>Eckhart Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 24, 1957</u>		REGISTRAR'S SIGNATURE <u>Winter K. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>B.H. Moore</u> ADDRESS <u>Hafer Funeral Home, Main, Frostburg, Md.</u>			

RECEIVED
JAN 10 1964

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JAN 10 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00042

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 69 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Miners Hospital				d. STREET ADDRESS 50 Beall St.			
3. NAME OF DECEASED (Type or print) First Middle Last James Alfred Jeffries				4. DATE OF DEATH Month Day Year Jan. 2 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8-1887	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Plumber		10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Jeffries				14. MOTHER'S MAIDEN NAME Mary Jane Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W. 1		16. SOCIAL SECURITY NO.		17. INFORMANT Address (brother) Clifton D. Jeffries, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion H.A.O. 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Also exposure to cold weather. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Jan. 2-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-4-57	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) Frostburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 1-4-57	24b. REGISTRAR'S SIGNATURE Miss Nancy H. Rose

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TOTAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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JAN 10 1957

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BUREAU V. S.

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27

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/8/57		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 110 Elkton Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle C. Last Keller				4. DATE OF DEATH Month January Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/2/1883		9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired: Heater		10b. KIND OF BUSINESS OR INDUSTRY Tin Mill Worker		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Keller				14. MOTHER'S MAIDEN NAME Harriet Crawfish			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis ? (c) Thrombo angioblastic obliterans ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH Sudden						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/8/57 , 19 to 1/20/57 , 19, that I last saw the deceased alive on 1/20/57 , 19, and that death occurred at 8:18 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 1/21/57							
ACTUAL SIGNATURE James F. Scarpelli M.D.				PHYSICIAN'S NAME (Type) Dr. J. E. McLean Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.				24a. REC'D BY REGISTRAR Jan 22, 1957		24b. REGISTRAR'S SIGNATURE W.R. Hark, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9
82 CERTIFICATE OF DEATH

00045

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Henry J. Kelsh				4. DATE OF DEATH Month Jan. Day 28 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min 58	IF UNDER 24 HRS Months 58 Days 58 Hours 58 Min 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minster		10b. KIND OF BUSINESS OR INDUSTRY M. E. Church		11. BIRTHPLACE (State or foreign country) Olar, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Kearse				14. MOTHER'S MAIDEN NAME Anna Strolman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War #1 217-10-2835		17. INFORMANT Grayson J. Kelsh-2017 Perry St., D. C.		Address Washington,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular Disease DUE TO (c) Indef.						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May 15, 1957 to May 28, 1957 , that I last saw the deceased alive on May 28, 1957 , and that death occurred at M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. B. Davis M.D.				DATE SIGNED 2-1-57			
PHYSICIAN'S NAME (Type) John B. Davis, M.D.				ADDRESS (Street, city or town, state) 2 Broadway, Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1st, 1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Pearl H. Mattingly				24a. REC'D BY REGISTRAR 2-1-57		24b. REGISTRAR'S SIGNATURE M. Young	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The to be completed by the attending physician and completely filled out by the funeral director, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

EB 5 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

28

CERTIFICATE OF DEATH

00046

Reg. Dist. No. 1

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>La</u> Last <u>Kerns</u>			4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1980</u>		9. AGE (In years last birthday) <u>76</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private homes</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>David W. Kerns</u>			14. MOTHER'S MAIDEN NAME <u>Robinette</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	17. INFORMANT <u>Patient's Chart</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-26</u> , 19 <u>57</u> , to <u>1-31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>		M.D. <u>62 Greene St.</u>		DATE SIGNED <u>2-1-57</u>	
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>		Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Feb. 2, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 8 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS 217 Dexter Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Shirley Middle Jean Last Kerns			4. DATE OF DEATH Month Jan. Day 31 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9-1929		9. AGE (In years last birthday) 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Newark, Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harold Preist			14. MOTHER'S MAIDEN NAME Goldie Nichols		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Hospital records Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor with hemorrhage 237x DUE TO Pulmonary edema Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 31-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Woodrow Cemetery		22d. LOCATION (City, town, or county) (State) Paw Paw, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Silcox Funeral Home, Cumberland, Maryland.			24a. RECEIVED BY REGISTRAR Feb. 1, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00048

DR. HALLINAN

30 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEAR CUMBERLAND, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS ROUTE #2, Williams Road	
3. NAME OF DECEASED (Type or print) First FRANK Middle KNIPPENBERG Last		4. DATE OF DEATH Month JANUARY Day 9 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 25, 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDYMAN		10b. KIND OF BUSINESS OR INDUSTRY WINDSOR HOTEL	9. AGE (In years last birthday) yrs. 62
11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY KNIPPENBERG		14. MOTHER'S MAIDEN NAME LUTISHIA LOGSDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-10-2082	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the Liver 580X DUE TO Acute yellow atrophy of the liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) none DUE TO (c) none		INTERVAL BETWEEN ONSET AND DEATH 10 days. 10 da.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 25, 1956 , to January 9, 1957 , that I last saw the deceased alive on January 9, 1957 , and that death occurred at 2:05 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Hallinan</i>		ADDRESS (Street, city or town, state) DATE SIGNED 140 Bedford St., Cumberland, Md. 1-9-57	
PHYSICIAN'S NAME (Type) DR. JAMES HALLINAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-12-57	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR Jan 11, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE <i>W.R. Frantz, M.D.</i>	

BUREAU K. S.

JAN 14 1957

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1

INSTRUCTIONS

TO A **DEATH CERTIFICATE** OR **HOSPITAL**: The law requires that the death certificate be extended within 24 hours after death. The copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR**: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

85
CERTIFICATE OF DEATH

00049

Reg. Dist. No. 9

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Allegany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Frostburg, R.F.D. # 1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Miners Hospital</u>				STREET ADDRESS <u>(If rural give location)</u>			
3. NAME OF DECEASED (Type or Print) <u>Magdalena Landerfeld</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1/9/1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 21 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Echart, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Conrad Kaumaff</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kukenbiser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>William Landerfeld, (SOM)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Chronic disease of Metastasis</u>						<u>6 mos.</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 19, 56</u> , to <u>Jan 9, 1957</u> , that I last saw the deceased alive on <u>Jan 9, 1957</u> , and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. B. Davis, M.D.</u>		M.D.		ADDRESS (Street, city, town, state) <u>2 Broadway, Frostburg, Md.</u>		DATE SIGNED <u>1/8/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/12/1957</u>		NAME OF CEMETERY OR CREMATORY <u>German Lutheran Cemetery, Frostburg, MD.</u>		LOCATION (City, town, or County) (State)	
24. REC'D BY REGISTRAR <u>1-12-57</u>		REGISTRAR'S SIGNATURE <u>Mrs. Nancy H. Rice</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorg, Lonaconing, MD</u>		ADDRESS	

BUREAU V. S.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Box 149 Hyndman</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>71 x 3</u>	
3. NAME OF DECEASED (Type or print) <u>HARVEY</u> First <u>Denzil</u> Middle <u>Leydig</u> Last		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>June 12-1921</u>	9. AGE (In years last birthday) <u>35</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clyde Slider, Con.</u>	11. BIRTHPLACE (State or foreign country) <u>Pa.</u>
13. FATHER'S NAME <u>Harry Leydig</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Memorial Hospital records</u>	
17. INFORMANT <u>Memorial Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Broken neck with severence of cervicle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>cord.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>gradual</u> <u>42 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>car pinned under car. Excessive speed on curve, hit utility pole, thrown out</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-40-57-Dec 8 1956</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route # 35</u>	20f. (City or town) (County) (State) <u>Ellerslie Allegany Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 19-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-22-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>D. O. F. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bedford Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harvey H. Ziegler</u>		24a. REC'D BY REGISTRAR <u>Jan. 20, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for 30 days.

RECEIVED
JAN 25 1967
BUREAU V. S.

32 CERTIFICATE OF DEATH

00051

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 5 DAYS				d. STREET ADDRESS 424 ARCH ST.			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CORA L LINN				4. DATE OF DEATH Month Day Year JANUARY 16, 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26 1875	9. AGE (In years last birthday) 81 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARCELLUE SMITH				14. MOTHER'S MAIDEN NAME MARGARET KELLY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia - DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c) Cholelithiasis							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholelithiasis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/2/57 , 19 57 , to 1/16/57 , 19 57 , that I last saw the deceased alive on 1/16/57 , 19 57 , and that death occurred at 8:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature] M.D.				ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 1/16/57			
PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-19-1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Jan 19, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

THIS HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 1957

BUREAU V. S.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 12/27/50 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland d. STREET ADDRESS Mexico Farms, Oldtown Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle CORELLIA Last Long		4. DATE OF DEATH Month January Day 26 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/1880
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76	IF UNDER 24 HRS. Hours 76 Min 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Weber		14. MOTHER'S MAIDEN NAME Caroline Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic Myocarditis 4 DUPLICATE DUE TO General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sporadic Paralysis (c) Arterio Sclerosis		INTERVAL BETWEEN ONSET AND DEATH ? ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio Sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/2/52 , 19 to 1/26/57 , 19 that I last saw the deceased alive on 1/26/57 , 19 and that death occurred at 11:30 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 1/28/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan. 29, 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Ht. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 30, 1957 24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1907

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00053

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>34</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W.Va.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wiley Ford</u>	
c. LENGTH OF STAY IN lb <u>10 days</u>		d. STREET ADDRESS <u>Welton St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Oscar</u> <u>Ed.</u> <u>Long</u>		4. DATE OF DEATH <u>Jan.</u> <u>19</u> <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>0 ct. 23-1899</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Long</u>		14. MOTHER'S MAIDEN NAME <u>Agnes George</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>214-05-9277</u>	
17. INFORMANT <u>Memorial Hospital records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial failure</u> <u>420.1</u> DUE TO <u>Diffuse coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac dilatation & Hypertrophy</u> DUE TO (c) <u>Pulmonary infarction(bilateral)</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>762X</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell between two car, East Yard Hump, B&O.R.Ry.</u>	
20c. TIME OF INJURY Month, Day, Year <u>2 July 25 19 48</u> Hour <u>2</u> a. m. <u>2</u> p. m. <u>2</u> a. m. <u>2</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>B&O.R.Ry</u>		20f. (City or town) <u>Cumberland, Allegany, Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>		<u>Jan. 19-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cem.</u>		22d. LOCATION (City, town, or county) <u>Cumb.</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb.</u>		24a. REC'D BY REGISTRAR <u>Jan. 21, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>			

REPUTED MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED
JAN 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00054

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Id.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2 Lonaconing</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>Laird</u> <u>Love</u>			4. DATE OF DEATH Month Day Year <u>Jan.</u> <u>7</u> <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23-1892</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery store</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>

13. FATHER'S NAME <u>Isaac Love</u>	14. MOTHER'S MAIDEN NAME <u>Mary Laird</u>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>W.W.I</u>	16. SOCIAL SECURITY NO. 17. INFORMANT Address <u>(brother) Isaac Love 2nd. Lonaconing, Md.</u>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion due to coronary sclerosis-sudden</u> DUE TO <u>mitral stenosis (calcified)</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiac hypertrophy</u> (c), stating the underlying cause last. DUE TO <u>Edema of brain (marked)</u> <u>Cerebral edema (marked)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 2</u> <u>YEARS</u> Yrs.
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D.	DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 8-1957</u>
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/10/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>German Lutheran Cemetery, Frostburg, MD.</u>	22d. LOCATION (City, town, or county) (State)
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23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>1/11/57</u>
24b. REGISTRAR'S SIGNATURE <u>Janette M. Boral</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 16 1917

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

2 months

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

205 Columbia St.

d. STREET ADDRESS

205 Columbia St.

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

Caroline N. Baggett

Luttrell

4. DATE
OF
DEATH

Jan.

Day

24

Year

19

57

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

July 24-1880

9. AGE (in years
last birthday)

76

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Virginia City, Nevada

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

? Oliver

14. MOTHER'S MAIDEN NAME

Caroline Lohry

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

550-38-7835

17. INFORMANT

Address

Son) John L. Baggett, Cumberland, Md.

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary occlusion

INTERVAL BETWEEN
ONSET AND DEATH

sudden

420.1

DUE TO

Coronary sclerosis

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

Arteriosclerosis

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

p. m.

19

20d. INJURY OCCURRED

While

of work

Not while

of work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and find that death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined cause ☐.ACTUAL
SIGNATURE

H. V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S
NAME (Type)

H. V. Deming M.D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

Jan. 25-1957

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Cremation

22b. DATE THEREOF

1/28.1957

22c. NAME OF CEMETERY OR CREMATORY

Lee Crematorium

22d. LOCATION (City, town, or county)

Washington, D. C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William H. Right, Cumberland, Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Jan. 26, 1957 M. R. Frank, M.D.

With corporate

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

IAN

RECEIVED

Outside of City Limits

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural LaVale Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural LaVale Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RFD #1 Cumb Md</u>				d. STREET ADDRESS <u>RFD I Cumb. Md</u>			
3. NAME OF DECEASED (Type or print) First <u>Adda</u> Middle <u>V.</u> Last <u>Macbeth</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>17</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1, 1868</u>	9. AGE (In years last birthday) <u>88</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Sowers</u>				14. MOTHER'S MAIDEN NAME <u>Mary Keyser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robert B. Macbeth</u> Address <u>RFD I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial</u> <u>592 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Serinitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>some years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov</u> 19 <u>56</u> to <u>Jan 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 10</u> , 19 <u>57</u> , and that death occurred at <u>LaVale Md</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. Allan G. Murray</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland Md</u>		DATE SIGNED <u>Jan 18/57</u>	
PHYSICIAN'S NAME (Type) <u>F. Allan G. Murray, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 18/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 19, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Bantz, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 17 1957
BUREAU V. S.

36 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN TB 14 DAYS			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 523 HENDERSON BOULEVARD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First WILLIAM Middle FILMORE Last MARKS			4. DATE OF DEATH Month JANUARY Day 31 Year 1957		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1876	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Irwin, Pa.	
13. FATHER'S NAME William B. MARKS			14. MOTHER'S MAIDEN NAME Henrietta Chorpenning		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Hospital Chart		17. INFORMANT Address Hospital Chart	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis - DUE TO Uremia - Progressed over 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia - Progressed over 1 month DUE TO: (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 1/17/57 , 19 57 , to 1/31/57 , 19 57 , that I last saw the deceased alive on 1/31/57 , 19 57 , and that death occurred at 11:28 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Richard J. Williams M.D. Cumberland 2/2/57					
ACTUAL SIGNATURE Richard J. Williams					
PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Maryland.		24a. REC'D BY REGISTRAR Feb. 2, 1957	24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1977

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

37

CERTIFICATE OF DEATH

00058

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>150 N. MEDICINE ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>STEWART</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>26</u> Year <u>1957</u>			
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-96</u>		9 AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CHINESE CORP.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALEXANDER MATTINGLY</u>				14. MOTHER'S MAIDEN NAME <u>VERONICA MURPHY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-07-6172</u>		17. INFORMANT <u>SISTER</u>		Address <u>18 R. 1000 E. ST. N. C.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>infection of Right foot</u> DUE TO <u>Pulmonary embolism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Five minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 11th</u> , 19 <u>56</u> , to <u>Jan 26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>January 26</u> , 19 <u>57</u> , and that death occurred at <u>_____</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Trevaskis, Sr.</u>				ADDRESS (Street, city or town, state) <u>Cumbersland, Maryland</u> DATE SIGNED <u>1/28/57</u>			
PHYSICIAN'S NAME (Type) <u>R. W. Trevaskis, Sr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 29, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Savage, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Jan 30, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. R. Frank, M.D.</u>	

BUREAU V. 8

FEB 1 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JULIA Middle ANN Last McGUIRE		4. DATE OF DEATH Month Jan. Day 23 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-2-1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 23 Days 19 Hours 57 Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework
10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward Wilderman	
14. MOTHER'S MAIDEN NAME Mary Lyons		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph McGuire, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Left Hemiplegia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis (c) ??			INTERVAL BETWEEN ONSET AND DEATH 8 Day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 16, 1957 to Jan 23, 1957 , that I last saw the deceased alive on Jan 22, 1957 , and that death occurred at 8:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE WOM Lane		DATE SIGNED Jan 25 1957	
PHYSICIAN'S NAME (Type) WOM Lane MD		ADDRESS (Street, City or town, state) Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-26-57	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		24a. REC'D BY REGISTRAR DATE 1-26-57	
ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Mrs. Nancy X. R...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law also requires that the death certificate be signed by the attending physician and completely filled out by the funeral director. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1977

RECEIVED

38 CERTIFICATE OF DEATH

Reg. Dist. No.

000604

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CITRILL</u>				c. LENGTH OF STAY IN 1b <u>2-1-VALE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W MCKENZIE</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 31 19 57</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FE. 27 1893</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEONOR J. MCKENZIE</u>				14. MOTHER'S MAIDEN NAME <u>Frances Maloney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>214-07-5738</u>		17. INFORMANT <u>PTS. CHART</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary sclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>circulation</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/20</u> 19 <u>57</u> to <u>1/31</u> 19 <u>57</u> , that I last saw the deceased alive on <u>1/3</u> 19 <u>57</u> , and that death occurred at <u>4:50 p.m.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>55 Greene St. Cumberland Md.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Elizabeth Brings</u> M.D. PHYSICIAN'S NAME (Type) <u>ELIZABETH BRINGS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sts. Peter & Paul Cemetery Cumberland, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland.</u>				24. REC'D BY REGISTRAR <u>Feb 2, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. F. Frantz, M.D.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

53 3 1957

BUREAU W. S.

39 CERTIFICATE OF DEATH

00061

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE 632 Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
		f. STREET ADDRESS 632 Columbia Ave	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Boyd Middle Miller Last Miller		4. DATE OF DEATH Month January Day 27 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/19/91
9. AGE (In years, last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 27 Days 19 Hours 57 Min.	11. IF UNDER 24 HRS Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Belmont Corp.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Miller		14. MOTHER'S MAIDEN NAME Agnes Hartsock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 1-4-57-4207	
17. INFORMANT pt's chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pylonephritis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/17 , 19 57 , to 1/27 , 19 57 , that I last saw the deceased alive on 1/26 , 19 57 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr.		ADDRESS (Street, city or town, state) 452 N. Centre St.	
PHYSICIAN'S NAME (Type) LEO H. LEY JR.		DATE SIGNED 1/27/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF Jan 30 1957	
22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Wright		24a. REC'D BY REGISTRAR Jan 28, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE W.R. Hantz M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Mo 21 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Last Miller First Etta Middle Maud		4. DATE OF DEATH Month 1 Day 7 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/96
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper at Home		10b. KIND OF BUSINESS OR INDUSTRY Pa.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dave Latta		14. MOTHER'S MAIDEN NAME Eve (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Pt's Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA - 48 HRS.			
DUE TO Pneumonia			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart			
DUE TO JAUNDICE + 11 HRS			
(c) Chronic liver disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/8/57 to 1/7/57 , that I last saw the deceased alive on 1/7/57 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. G. WEISMANN		ADDRESS (Street, city or town, state) CUMBERLAND, MD.	
PHYSICIAN'S NAME (Type) S. G. WEISMANN, M.D.		DATE SIGNED 1-7-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/57	
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.	
23a. REC'D BY REGISTRAR 1/8/57		23b. REGISTRAR'S SIGNATURE W. Frank M.D.	

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CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 70 yrs1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION State Street		d. STREET ADDRESS State Street	
3. NAME OF DECEASED (Type or print) Eilbeck		4. DATE OF DEATH 1/3/1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Moses		14. MOTHER'S MAIDEN NAME Hannah Teasdale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or date of service)		16. SOCIAL SECURITY NO	
17. INFORMANT William Russell Moses, Lonaconing, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH none many yrs. many yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 56 , to Jan , 19 57 , that I last saw the deceased alive on Jan , 19 57 , and that death occurred at 2 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/6.1957	
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 1-8-57	
24b. REGISTRAR'S SIGNATURE Jeanette M. Boal			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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JAN 11 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00064

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Thomas</u> Last <u>Mouse</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>31</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 4-1956</u>
9. AGE (In years last birthday) <u>0 yrs.</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis Mouse</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Powers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(father) Francis Mouse, Cumberland, Md.</u>	
17. INFORMANT <u>(father) Francis Mouse, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock due to burns from scalding hot water. 2 1/2 hrs</u> <u>911.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>also had pulmonary edema.</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>*</u>		20b. DESCRIBE HOW INJURY OCCURRED (State, nature, cause, place, and time of injury) <u>scalding hot water, which spilled over baby body. Rolled off of couch, body hit steam cooker filled with</u>	
20c. TIME OF INJURY Month, Day, Year <u>11:55 a.m. Jan. 31 19 57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Cumberland, Allegany, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 31-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 2, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Feb. 1, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. L. Frantz, M.D.</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please advise the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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BUREAU A. G.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Maryland	
c. LENGTH OF STAY IN 1b 7 yrs		d. STREET ADDRESS 184 N Centre St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 184 Centre St		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles First Dominick Middle Mudd Last		4. DATE OF DEATH Month 1- Day 25 Year 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 29-1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Automobile Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Charles County, Maryland USA	
11. BIRTHPLACE (State or foreign country) Charles County, Maryland USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard M. Mudd		14. MOTHER'S MAIDEN NAME Anna Franklin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 1907 to 1915 578-I6-1051	
17. INFORMANT Barbara E. Mudd		Address 184 N Centre St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 4 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-18 , 19 56 , to 1-25 , 19 57 , that I last saw the deceased alive on 1-25 , 19 57 , and that death occurred at 12:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED _____			
ACTUAL SIGNATURE Ralph W. Ballin M.D.		ADDRESS 62 Greene St.	
PHYSICIAN'S NAME (Type) Ralph W. Ballin		Cumberland, Md. 1-26-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-29-57	22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Va.	
22d. LOCATION (City, town, or county) (State)		22e. REC'D BY REGISTRAR Jan 28, 1957	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24b. REGISTRAR'S SIGNATURE W. H. Hantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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CERTIFICATE OF DEATH

00066

Reg. Dist. No.

43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE Maryland		COUNTY Allegany			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland		LENGTH OF STAY (In this place) 72 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 521 Essex Place				STREET ADDRESS (If rural give location) 521 Essex Place			
3. NAME OF DECEASED (First) (Middle) (Last) Andrew C. Mullan				4. DATE OF DEATH (Month) (Day) (Year) Jan. 9 1957			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 13, 1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if Retired) Steamfilter Textile			10b. KIND OF BUSINESS OR INDUSTRY Textile		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Mullan				14. MOTHER'S MAIDEN NAME Catherine Petri			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO 217-10-1283		17. INFORMANT & ADDRESS Miss Kathleen Mullan, Cumberland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) Acute Coronary Embolus				INTERVAL BETWEEN ONSET AND DEATH 9 hours			
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Atherosclerosis				Not known			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-9-1957 , to 1-9-1957 , that I last saw the deceased alive on 1-9-1957 , and that death occurred at 5:25 M., from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) Cumberland Md.		DATE SIGNED 1-11-57	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1-12-57		NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		LOCATION (City, town, or county) Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, MD.			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the third copy of this certificate must be filed with the funeral director, the third copy of this certificate must be filed with the funeral director, the third copy of this certificate must be filed with the funeral director.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the third copy of this certificate must be filed with the funeral director, the third copy of this certificate must be filed with the funeral director, the third copy of this certificate must be filed with the funeral director.

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U. S. AIR FORCE

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00067

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at the Memorial Hospital				e. STREET ADDRESS 419 Dunbar Drive			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Calton Middle Louis Last NEWMAN				4. DATE OF DEATH Month Jan. Day 6 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2-1898	
9. AGE (in years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days 		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Gr. Supreme Amusement Co. Cumberland, Md.				11. BIRTHPLACE (State or foreign country) U.S.A.			
13. FATHER'S NAME Cranston Newman				14. MOTHER'S MAIDEN NAME Nahcy Meiers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 219-14-613P			
17. INFORMANT Newman				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis-occlusion 430.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H. V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 7-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 9, 1957		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE George Funeral Home, Cumberland, Maryland.				24a. REC'D BY REGISTRAR Jan. 8, 1957			
				24b. REGISTRAR'S SIGNATURE W. R. Frank M.D.			

RECEIVED
JAN 10 1957
BUREAU V. S.

1 Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00068

Item 9 Film G209 1-5-57, et

45

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 18 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				d. STREET ADDRESS 1025 KENT AVE.,			
3. NAME OF DECEASED (Type or print) First ROBERT Middle EARL Last NICKEL				4. DATE OF DEATH Month JANUARY Day 2 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 21, 1891	9. AGE (In years last birthday) 65 yrs	IF UNDER 1 YEAR Months 2 Days 19		IF UNDER 24 HRS. Hours 19 Min 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Grocer				10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOHN G. NICKEL				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Martha Nickel Cumb. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - (c) -						INTERVAL BETWEEN ONSET AND DEATH 15 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from July , 1957, to Jan , 1957, that I last saw the deceased alive on Jan 2 , 1957, and that death occurred at 12:48 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE St. Herman				ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md			
DATE SIGNED 1/3/57							
PHYSICIAN'S NAME (Type) H. O. Himmelwright, M.D.							
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF Jan 5, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumberland		24. REC'D BY REGISTRAR Jan 3, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Rantz M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that this death certificate be executed within 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

APR 2 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00069

DR. HIMMELWRIGHT

46

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 3 DAYS				d. STREET ADDRESS 125 HENRY STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SHARON Middle D. Last PARSONS				4. DATE OF DEATH Month JANUARY Day 27 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 27, 1949		9. AGE (In years last birthday) yrs. 7	IF UNDER 1 YEAR Months 27 Days 19 Hours 57	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Keyser	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HERMAN D. PARSONS				14. MOTHER'S MAIDEN NAME HELEN J. COSNER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Vascular 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 56 , to Jan , 19 57 , that I last saw the deceased alive on Jan 27 , 19 57 , and that death occurred at 3:07 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Himmelwright				ADDRESS (Street, city or town, state) 133 Va. Ave, Cumberland, Md			
DATE SIGNED 1/27/57							
PHYSICIAN'S NAME (Type) DR. G. OVERTON HIMMELWRIGHT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF I-29-57		22c. NAME OF CEMETERY OR CREMATORY Maysville Cem.		22d. LOCATION (City, town, or county) (State) Maysville, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 28, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.			

BUREAU V. S.

JAN 16 1957

RECEIVED

Within corporate limits

47
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1414 River Ave		d. STREET ADDRESS 1414 River Ave.	
3. NAME OF DECEASED (Type or print) First Joseph Middle Cleveland Last Peer		4. DATE OF DEATH Month January Day 25 , Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Fireman		10b. KIND OF BUSINESS OR INDUSTRY Electric company	
11. BIRTHPLACE (State or foreign country) Augusta, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Peer		14. MOTHER'S MAIDEN NAME Rebecca Lambert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-9537A	
17. INFORMANT Mrs. Clara Fadley Peer, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June 1956 to Jan. 25, 1957 , that I last saw the deceased alive on Jan. 10, 1957 , and that death occurred at 8:00 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay E. Durrett M.D.		ADDRESS (Street, city or town, state) Cumberland - Md DATE SIGNED 1/27/57	
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 27, 1957	22c. NAME OF CEMETERY OR CREMATORY Three Churches Cemetery	22d. LOCATION (City, town, or county) (State) Three Churches, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland,		24a. REC'D BY REGISTRAR Jan 27, 1957 24b. REGISTRAR'S SIGNATURE W. R. Hantz, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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11 A 11111

DR. MIRKIN

48

CERTIFICATE OF DEATH

Reg. Dist. No.

00071

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
c. LENGTH OF STAY IN 1b 19 DAYS							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK MEMORIAL HOSPITAL AVE.				d. STREET ADDRESS THE DINGLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MORTON Middle W Last PESKIN				4. DATE OF DEATH Month JANUARY Day 7 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1893		9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months 3 Days 17
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10b. KIND OF BUSINESS OR INDUSTRY Shoe Store		11. BIRTHPLACE (State or foreign country) OHIO	
13. FATHER'S NAME PHILIP PESKIN				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME CARRIE LEVY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) yes		16. SOCIAL SECURITY NO. 220-28-9402		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Lower nephron nephrosis DUE TO (c) Acute hemorrhagic pancreatitis							INTERVAL BETWEEN ONSET AND DEATH 18 days 16 days 19 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Oliguria, hyperglycemia, pneumonia three lobes at intervals							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19 1956 , to Jan 7 , 1957, that I last saw the deceased alive on Jan 7 , 1957, and that death occurred at 3:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing St. Cumberland, Md. DATE SIGNED 1/8/57							
ACTUAL SIGNATURE Samuel M. Jacobson		M.D. 50 Pershing St. Cumberland, Md.					
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 9, 1957		22c. NAME OF CEMETERY OR CREMATORY East View Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR Jan 9, 1957		24b. REGISTRAR'S SIGNATURE W. L. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JAN 11 1957

RECEIVED

85 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sand Spring</u>				d. STREET ADDRESS <u>Sand Spring</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma A. Pfaff</u>				4. DATE OF DEATH Month Day Year <u>18 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30-1892</u>	9. AGE (In years last birthday) <u>64</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Finzel, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Peter Caton</u>				14. MOTHER'S MAIDEN NAME <u>Clara McKenzie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>7</u>		17. INFORMANT <u>Charles Pfaff, Son, Sand Spring, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (Massive)</u> <u>443x</u> DUE TO <u>Hypertensive Cardio-vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs.</u> DUE TO (c) <u>5 yrs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 1951, to <u>1-18</u> , 1957, that I last saw the deceased alive on <u>1-18</u> , 1957, and that death occurred at <u>3 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.C. Diehl</u>				DATE SIGNED <u>1/19/57</u>			
PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>				ADDRESS <u>Frostburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B.N. Montesano, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR <u>Wm. Henry H. Rose</u>			
24b. REGISTRAR'S SIGNATURE				DATE <u>1-21-57</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1 105

RECEIVED
JUN 10 1905

49

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/16/52	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Frostburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Hannah Middle E. Last Powell			4. DATE OF DEATH Month January Day 25 Year 1957		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/1873		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Charles F. Ramhoff		
14. MOTHER'S MAIDEN NAME Rebecca Biddinger			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO			17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c) Chronic Nephritis					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Dementia					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/16/52 , 19 to 1/25/57 , 19 that I last saw the deceased alive on 1/25/57 , 19 and that death occurred at 6:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 1/26/57					
ACTUAL SIGNATURE James E. McLean M.D.			PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-28-1957	22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,			ADDRESS Frostburg, Md.		24. REC'D BY REGISTRAR Jan 27, 1957
			24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

1957

IN

50

JUL - 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarysville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart Mines</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>Highway #40 & intersection 55</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway #40 & intersection 55</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>E.</u> Last <u>Rankin</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>19 57</u>					
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13-1924</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton Rankin</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Chaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>218-16-3932</u>		17. INFORMANT <u>(brother) John Rankin, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured cervical vertebrae right clavicle- sudden.</u> DUE TO <u>Fractured ribs-1 to 4, left, 2, 3 & 4 right</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Right ear torn off. Auto accident.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Opposite side of road & he was thrown out.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Down grade, excessive speed, hit curb then guardrail</u>					
20c. TIME OF INJURY Month, Day, Year <u>12.20-1-13 19 57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway Rt. 40</u>	20f. (City or town) <u>Clarysville</u>	(County) <u>Allegany</u>	(State) <u>Md.</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Jan. 13-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-15-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bush H. Moutson</u>		ADDRESS <u>23 E. Main, Frostburg, Md.</u>		24a. REC'D BY REGISTRAR <u>1-16-57</u>		24b. REGISTRAR'S SIGNATURE <u>M. Nancy N. Roe</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00075

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u> c. LENGTH OF STAY IN 1b <u>49 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dan's Mt. near Wolf Rock.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>John</u> Middle <u>Ravenscroft</u> Last 4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>19 57</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 24-1907</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 24 HRS Hours _____ Min. _____ 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired - coal miner</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Mining coal</u> 11. BIRTHPLACE (State or foreign country) <u>Vale Summit, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
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13. FATHER'S NAME <u>John Thomas Ravenscroft</u>	14. MOTHER'S MAIDEN NAME <u>Mary Jane Swager</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>W.W.2</u>	16. SOCIAL SECURITY NO <u>216-05-2946</u>	17. INFORMANT Address _____ <u>(brother) Wilson G. Ravenscroft, Midland, Md.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>about 3 or 4 yrs.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____
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21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>H. V. Deming M.D.</u> M.D. EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 2-1957</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/4/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lonaconing, MD.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS _____ <u>George Eichhorn, Lonaconing, MD.</u>	24a. REC'D BY REGISTRAR DATE <u>1-3-57</u> 24b. REGISTRAR'S SIGNATURE <u>Janette M. Boal</u>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 7 1957

BUREAU V. B.

DR. HIMMELWRIGHT

50 CERTIFICATE OF DEATH

Reg. Dist. No.

00076

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 634 ELM STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNIE Middle AGNES Last ROBINETTE		4. DATE OF DEATH Month JANUARY Day 27 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 6, 1890
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 27 Days 19 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN K. BARTIK		14. MOTHER'S MAIDEN NAME JOSEPHINE SWACK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 240X (b) Hypertensive Cardiovascular Disease DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 54 , to Jan , 19 57 , that I last saw the deceased alive on Jan. 27 , 19 57 , and that death occurred at 3:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1/27/57			
ACTUAL SIGNATURE [Signature] M.D.			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright, Md.		133 Virginia Ave. Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF I-30-57	
22c. NAME OF CEMETERY OR CREMATORY St. Marys Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Jan 28, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

BUREAU V. S.

JAN 10 1977

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00077

51

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/15/56	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, rural	
		d. STREET ADDRESS Rt.#1, Box 64	
		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Emory Last Ross		4. DATE OF DEATH Month January Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/1878
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Lacy William Ross		14. MOTHER'S MAIDEN NAME Amanda Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypertension 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 18 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/15/56 , 19____, to 1/29/57 , 19____, that I last saw the deceased alive on 1/29/57 , 19____, and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.	
DATE SIGNED 1/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-2-1957	
22c. NAME OF CEMETERY OR CREMATORY Frostburg, Md.		22d. LOCATION (City, town, or county) (State) Frostburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Paul Dr. [illegible]		24a. REG'D BY REGISTRAR Feb 2, 1957	
ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE W. L. [illegible]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 6 1957

RECEIVED

52

CERTIFICATE OF DEATH

Reg. Dist. No.

4

Within corporate limits

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 10 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL & WARWICK AVES				d. STREET ADDRESS 11 VIRGINIA AVE.,			
3. NAME OF DECEASED (Type or print) First ROBERT Middle L. Last ROYCE				4. DATE OF DEATH Month JANUARY Day 14 Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 28, 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT L. ROYCE SR.				14. MOTHER'S MAIDEN NAME S. SHIRLEY A. CAPOROSSI			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL-CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Infection - Acute Bronchitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adrenal hemorrhages DUE TO (c) Congenital Cirrhosis of Liver							INTERVAL BETWEEN ONSET AND DEATH 1-10-57 1-10-57 July 1956
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital Cirrhosis of Liver with multiple hemorrhages throughout body.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1-10 , 1957, to 1-14 , 1957, that I last saw the deceased alive on 1-14 , 1957, and that death occurred at 9:40 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H. W. Eliason				ADDRESS (Street, city or town, state) 126 Union St. Cumberland Md			
PHYSICIAN'S NAME (Type) H. W. Eliason				DATE SIGNED 1/15/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-17-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 17, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JAN 21 1957

RECEIVED

53

CERTIFICATE OF DEATH

00079

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>103 Lafayette Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Upton</u> First <u>Lewis</u> Middle <u>Rummer</u> Last				4. DATE OF DEATH <u>Jan 22, 1957</u> Month <u>Jan</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1886</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	IF UNDER 24 HRS: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Brickmaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B + O</u>		11. BIRTHPLACE (State or foreign country) <u>Green Ridge Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. L. Rummer</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rebecca Sorrels</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>705-09-8690</u>		17. INFORMANT <u>Mrs. Sarah Johnson</u> Address <u>Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Haemica</u> DUE TO <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>—</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov. 1956</u> , to <u>Jan 22, 1957</u> , that I last saw the deceased alive on <u>Jan. 20, 1957</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.							
ACTUAL <u>Clay E. Durrett</u> M.D.				ADDRESS (Street, city or town, state) <u>236 24th Ave. Cumberland Md</u>			
DATE SIGNED <u>1/23/57</u>							
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) <u>Cumberland Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u>				24a. REC'D BY REGISTRAR <u>Jan 24, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Walter R. Frantz, Md</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

51

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES NEWTON RUNKLES				4. DATE OF DEATH Month JANUARY Day 8 Year 19 57.			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 7, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WHOLESALE GROCER				10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS J. RUNKLES			
14. MOTHER'S MAIDEN NAME CAROLINE BUCY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm 431X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 2 days (?)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov , 1954, to 1/8 , 1957, that I last saw the deceased alive on 1/8 , 1957, and that death occurred at 8:45 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Union St Cumberland Md DATE SIGNED 1/8/57							
ACTUAL SIGNATURE George M. Simons M.D.				PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/11/57		22c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY		22d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE H. LEE. SILCOX CUMBERLAND, MD.				24a. REC'D BY REGISTRAR Jan 11, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FRANKLIN D. ROOSEVELT

JAN 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00081

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 4 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edgar Middle H. Last Schaub				4. DATE OF DEATH Month Jan. Day 11 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13-1886	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 70		IF UNDER 24 HRS. Hours 70 Min. 70			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired accountant				10b. KIND OF BUSINESS OR INDUSTRY Pitts.C, Coal Co		11. BIRTHPLACE (State or foreign country) Frostburg, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Frank Schaub				14. MOTHER'S MAIDEN NAME Anna Broderick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 234-09-7702			
17. INFORMANT (wife) Marie R. Schaub, Cumberland, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan. 11-1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.				24a. REC'D BY REGISTRAR Jan. 14, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frank M.D.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

RECEIVED

JAN 16 1907

BUREAU V. S.

56 CERTIFICATE OF DEATH

Reg. Dist. No. 00082

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAYESVILLE	
c. LENGTH OF STAY IN 1b 3 DAYS		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle SUSAN Last SEARS		4. DATE OF DEATH Month JANUARY Day 2 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1892
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Grant County, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER L. SEARS		14. MOTHER'S MAIDEN NAME PORTER, ANNA C.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left breast with metastasis to liver & left pleura DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cachexia secondary to carcinoma (c) Cachexia secondary to carcinoma			INTERVAL BETWEEN ONSET AND DEATH Approx 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 28, 1956 , to Jan 2, 1957 , that I last saw the deceased alive on Jan 2, 1957 , and that death occurred at 9:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. Faw, Jr. M.D.		ADDRESS (Street, city or town, state) Cumbersville W. Va. DATE SIGNED Jan 3 57	
PHYSICIAN'S NAME (Type) W. M. Faw, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 5, 1957	22c. NAME OF CEMETERY OR CREMATORY Mayesville Cemetery	22d. LOCATION (City, town, or county) (State) Mayesville W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Blaine Schaffner ADDRESS Petersburg, W. Va.		24a. REC'D BY REGISTRAR Jan 4, 1957	24b. REGISTRAR'S SIGNATURE W. H. Priddy M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00083

DR. BALLIN

57

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY HAMPSHIRE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 57-13			
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH SHANHOLTZ				4. DATE OF DEATH Month Day Year JANUARY 13 19 57			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8, 1897	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) RAWLINGS, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRED J. LEASE				14. MOTHER'S MAIDEN NAME MARGARET EISENHOUR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 4-0111		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4214 DUE TO Valvular Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 mos 23 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 August , 19 54 , to 1-13 , 19 57 , that I last saw the deceased alive on 1-13 , 19 57 , and that death occurred at 3:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 1-13-57 ACTUAL SIGNATURE Ray W. Ballin M.D. PHYSICIAN'S NAME (Type) DR. BALLIN Cumberland Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 15 1957		22c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Greenspring, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John Guthrie				ADDRESS Springfield, Va.		24a. REC'D BY REGISTRAR DATE Jan 14 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Frank M.D.			

BUREAU V. 3

AN 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00084

58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 1900 BEDFORD STREET	
3. NAME OF DECEASED (Type or print) First JAMES Middle MONROE Last SHARER		4. DATE OF DEATH Month JANUARY Day 26 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 20, 1903
9. AGE (In years last birthday) 53 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Plumbing Business	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? WK U.S.A.	
13. FATHER'S NAME WALTER O. SHARER		14. MOTHER'S MAIDEN NAME Rebecca HERING	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Memorial Hospital, Cumberland, Maryland.	
17. INFORMANT Memorial Hospital, Cumberland, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH From 7:20 AM			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 1:20 , 19 57 to 1-26-1957 , that I last saw the deceased alive on 1-26-1957 , and that death occurred at 9:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 1-28-57			
ACTUAL SIGNATURE W. F. Williams		PHYSICIAN'S NAME (Type) W. F. Williams, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1957	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland,	
23. FUNERAL DIRECTOR'S SIGNATURE George Funeral Home, Cumberland, Maryland.		ADDRESS _____	
24a. REC'D BY REGISTRAR Jan. 28, 1957		24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	

BUREAU V. S.

JAN 1957

RECEIVED

59 CERTIFICATE OF DEATH

00085

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegheny</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cumberland</u>		<u>1 Yr. 2 Mo. 8 Da.</u>		TOWN <u>Cumberland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat, Furnace St.</u>				STREET ADDRESS (If rural give location) <u>317 5th St.</u>			
3. NAME OF DECEASED (Type or Print) <u>James A. Garfield Shoemaker</u>				4. DATE OF DEATH <u>11 21 19 57</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>June 14, 1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sawmiller</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Shoemaker</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Tioy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Agnes Shoemaker, Cumberland, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
4222. IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>				<u>Chronic Myocarditis</u>		<u>72 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Cerebral Thrombosis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>Cerebral Arteriosclerosis</u>		<u>?</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 3, 1957</u> to <u>Jan 21, 1958</u> , that I last saw the deceased alive on <u>Jan 23, 1958</u> , and that death occurred at <u>11:21 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James S. McLean, M.D.</u>		ADDRESS (Street, city, town, State) <u>49 Grace St. Cumberland, Md.</u>		DATE SIGNED <u>1/23/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 27, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>White Oak Cemetery</u>		LOCATION (City, town, or county) (State) <u>Near Sellersburg, Pa.</u>	
24. REC'D BY REGISTRAR <u>Jan 26, 1958</u>		REGISTRAR'S SIGNATURE <u>Winters R. Frantz, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Willie M. H. Kight, Cumberland, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be secured within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

8 A. 111111

LEAVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00086

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>9 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>			d. STREET ADDRESS <u>4118 LIVERLY TERRACE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>SHOWACRE</u> Last <u>SHOWACRE</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>12</u> Year <u>1957</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 25, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpentry</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>PHILLIP C. Showacre</u>			14. MOTHER'S MAIDEN NAME <u>JANE STUMP</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, none unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>None</u>	17. INFORMANT <u>OLD CHART OF 9/3, -56.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissected Pyloric Ulcer (Large)</u> - DUE TO <u>Bronchial Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>48 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>1-5</u> , 19 <u>57</u> , to <u>1-12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-12</u> , 19 <u>57</u> , and that death occurred at <u>5:56</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>James J. Johnson</u>		M.D.		ADDRESS (Street, city or town, state) <u>Cumberland Md</u>	
PHYSICIAN'S NAME (Type) <u>James J. Johnson</u>		DATE SIGNED <u>1-12-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/13/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumb. Md</u>	24a. REC'D BY REGISTRAR <u>Jan 12, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. L. Frank M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JAN 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

61

CERTIFICATE OF DEATH

00087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS East Main Street	
3. NAME OF DECEASED (Type or print) First Barbara Middle Scott Last Smith		4. DATE OF DEATH Month 12 Day 21 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/14/ 1879
9. AGE (In years last birthday) 77 yrs		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Scott		14. MOTHER'S MAIDEN NAME Jean McMillian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Andrew Smith, Lonaconing, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis + Thrombosis (Husband) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Congestive heart failure (c) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs. 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21, 1956 to Jan 21, 1957 , that I last saw the deceased alive on Jan 21, 1957 , and that death occurred at 12:57 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Leslie R. Miles, Jr. M.D.		PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D. Lonaconing, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		24a. REC'D BY REGISTRAR DATE 1-24-57	
24b. REGISTRAR'S SIGNATURE Mr. Stanley H. Pas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, rural		c. LENGTH OF STAY IN 1b 6mo near Cumberland, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bowmans Addition, R.F.D. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daisy Middle Ann Last Smith		4. DATE OF DEATH Month Jan Day 2 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1886
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Attn. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper At Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Andrew Wilson		14. MOTHER'S MAIDEN NAME Martha Bollman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT J. Perry Smith		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-20 , 19 56 to 1-2 , 19 57 , that I last saw the deceased alive on 1-2 , 19 57 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 1-3-57			
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St.	
PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/57	22c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery	22d. LOCATION (City, town, or county) (State) Flintstone, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 4, 1957		24b. REGISTRAR'S SIGNATURE Walter K. Harris, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 7 1957

RECEIVED

Items 6,9 Film 21 2-5-57 et

62

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/20/53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
		f. STREET ADDRESS West Main Street	
3. NAME OF DECEASED (Type or print) First Edith Middle Steinley Last Steinley		4. DATE OF DEATH Month January Day 22 Year 1957	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 2/10/1872
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Storekeeper	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 301x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Chronic Hypertension			INTERVAL BETWEEN ONSET AND DEATH 72 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hepatitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/20/53 , 19____, to 1/22/57 , 19____, that I last saw the deceased alive on 1/21/57 , 19____, and that death occurred at 12:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) 49 Greene St.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		DATE SIGNED 1/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/57	
22c. NAME OF CEMETERY OR CREMATORY Allegany County Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland		24. REC'D BY REGISTRAR Jan 23, 1957	
		24b. REGISTRAR'S SIGNATURE W. H. Kight, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 11 1937

RECEIVED

Within corporate limits

63

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 HRS. 10 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES				d. STREET ADDRESS 419 x INDEPENDENCE STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First CARLYLE Middle M. Monroe Last STEWARD		4. DATE OF DEATH		Month JANUARY Day 20 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1899	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman		10b. KIND OF BUSINESS OR INDUSTRY B & O RR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD STEWARD				14. MOTHER'S MAIDEN NAME JOSEPHINE DAWSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW 1 213-12-9353		17. INFORMANT Mrs. Carlyle Steward, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Coronary insufficiency						INTERVAL BETWEEN ONSET AND DEATH 12 hr 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 1, 1952 to 1/20, 1957 , that I last saw the deceased alive on 1/20, 1957 , and that death occurred at 8:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George M. Simons M.D.				ADDRESS (Street, city or town, state) 128 Union St. Cumberland, Md.			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/57		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Lutheran Cem		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				24a. REC'D BY REGISTRAR Jan 23, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1914

BUREAU V. S.

JAN

RECEIVED

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed and within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00091

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Allegany</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u> COUNTY <u>Allegany</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cumberland</u>		LENGTH OF STAY (In this place) <u>2mo. 2 da.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Barton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sylvan Retreat</u>				STREET ADDRESS (If rural give location) <u>Barton</u>			
3. NAME OF DECEASED (Type or Print) <u>James H.A. Sutherland</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14, 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Dec. 15, 1866</u>		9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>High-master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal - line</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Abraham Sutherland</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>2-3-66-10-18</u>		17. INFORMANT & ADDRESS <u>Cliffton Sutherland, Barton, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary Hypertension</u>						<u>36 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Hypertension</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>General arteriosclerosis</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Severe prosthesis</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 12, 1956</u>, to <u>Jan. 14, 1957</u>, that I last saw the deceased alive on <u>Jan. 13, 1957</u>, and that death occurred at <u>12:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James H. Sutherland</u> M.D.				ADDRESS (Street, city, town, state) <u>145 E. Second St., Baltimore, Md.</u>		DATE SIGNED <u>1-14-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 17, 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Philos</u>		LOCATION (City, town, or county) (State) <u>Westport Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan. 17, 1957</u>		REGISTRAR'S SIGNATURE <u>Winter R. Grant, Md.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Grant</u>		ADDRESS <u>Westport, Md.</u>	

U. S. A.

JAN 1967

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>over 40 Yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural* Flintstone Rt. 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Williams Rd. near Flintstone</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> <u>Curtis</u> <u>Teeter</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22-1911</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Odd jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>Petersburg, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Y. Teeter</u>		14. MOTHER'S MAIDEN NAME <u>Emily C. Nelson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-2084</u>	
17. INFORMANT <u>(brother) B.F. Teeter</u>		Address <u>Flintstone, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (apoplexy)</u> 592x DUE TO (b) <u>Chronic glomeruli nephritis with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertention</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <u>2</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 4-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>1/7/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glendale Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Flintstone, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>Jan. 7 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. D. Frank M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

RECEIVED
JAN 9 1957
BUREAU

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 1 year	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Greene St.		d. STREET ADDRESS 118 Greene St.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joseph Middle Tofani Last Tofani		4. DATE OF DEATH Month January Day 27 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1874
9. AGE (In years to ^{last} birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 1 Days 27 Hours 57 Min.	11. IF UNDER 24 HRS Months 1 Days 27 Hours 57 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction foreman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Province of Rome, Italy
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Anthony Tofani	
14. MOTHER'S MAIDEN NAME Rachel Bragalone		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 705-10-6143		17. INFORMANT Mrs. J. Donald Stillwagon, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid colon with metastases DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from April 1, 1956 to 1-27, 1957 , that I last saw the deceased alive on 1-27, 1957 , and that death occurred at 7:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James T. Johnson, Jr. M.D.		ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 1-29-57	
PHYSICIAN'S NAME (Type) James T. Johnson, Jr.		16 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 30, 1957	22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cemetery	22d. LOCATION (City, town, or county) Cumberland, Md. (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR Jan 30, 1957	24b. REGISTRAR'S SIGNATURE W. K. Frantz, M.D.

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00094

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wrights Crossing (rural)</u>			
c. LENGTH OF STAY IN 1b <u>9 hrs.</u>				d. STREET ADDRESS <u>Rt. #1-Box 6 Frostburg, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Muncie Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cecil Ashworth Tomlinson</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>13</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 11-1878</u>	
9. AGE (in years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Miner</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Aaron Tomlinson</u>	
14. MOTHER'S MAIDEN NAME <u>Rachael Barnard</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-10-1244</u>		17. INFORMANT <u>Fred Wilson, Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>traumatic shock, compound fracture of lower</u> DUE TO (b) <u>Fractured left femur, depressed comminuted fracture, left frontal bone & laceration.</u> DUE TO (c) <u>Walking on highway, hit by an auto.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>hit him. Walking on road, an auto attempting to pass another auto</u>			
20c. TIME OF INJURY Month, Day, Year <u>9.10 p.m. Jan. 12 19 57</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> <u>at work at work</u>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>near</u>				20f. CITY OR TOWN (County) (State) <u>Frostburg, Allegany Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				DATE SIGNED <u>Jan. 13-1957</u>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg Md.</u>		22d. LOCATION (City, town, or county) (State) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reuben H. Monticant</u>				24a. REC'D BY REGISTRAR <u>23 E. Main, Frostburg, Md.</u>			
24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. Rose</u>				DATE <u>1-16-57</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00095

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Allegany Grove</u>				c. LENGTH OF STAY IN 1b <u>43 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Allegany Grove (rural)</u>				d. STREET ADDRESS <u>R.F.D.#1 Cumberland, Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D.#1 Cumberland, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>W.</u> Last <u>Trenton</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26 1877</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired-Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kelley-Springfield</u>		11. BIRTHPLACE (State or foreign country) <u>Westernport, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph F. Trenton</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Gilbert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>(son) Joseph L. Trenton, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> about <u>15 min.</u> DUE TO (b) <u>Coronary sclerosis</u> ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Arteriosclerosis</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Jan. 16-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Westernport, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kight Funeral Home, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Jan 17, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, page 4 should be cut out of this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with farm permit. Page 5 may be retained for 30 days. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 21 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. STREET ADDRESS R.F.D.#2 Keyser, W.Va.	
3. NAME OF DECEASED (Type or print) First Gerald Middle Monzel Last VanMeter		4. DATE OF DEATH Month Jan. Day 12 Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7-1945
9. AGE (in years last birthday) 11 yrs.		10. IF UNDER 1 YEAR Months 11 Days 12	11. IF UNDER 24 HRS. Hours 12 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Short Gap School	
11. BIRTHPLACE (State or foreign country) Short Gap, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence A. VanMeter		14. MOTHER'S MAIDEN NAME Lorena M. Whitacre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Memorial Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 936.6 DUE TO Brain tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fore			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING? <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally hit on the head with a snowball.	
20c. TIME OF INJURY Month, Day, Year 8. 45-1-9 19 57		20d. PLACE OF INJURY (Home, farm, factory, etc.) Before School	
20e. PLACE OF INJURY (Home, farm, factory, etc.) Before School		20f. (City or town) (County) (State) Short Gap, Mineral W.Va.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1957	
22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery		22d. LOCATION (City, town, or county) (State) near Short Gap, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Maryland.		ADDRESS	
24a. REC'D BY REGISTRAR Jan. 14, 1957		24b. REGISTRAR'S SIGNATURE W.R. Frantz, M.D.	

JAN 16 1957

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BUREAU V. S.

CERTIFICATE OF DEATH

00097

Reg. Dist. No. 4

68

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Allegany		STATE MARYLAND		STATE Maryland		COUNTY Allegany	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cumberland		43 yrs.		TOWN Cumberland			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
114 New Hampshire Ave.				114 New Hampshire Ave.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Paul (Middle) Raymond (Last) Weber				(Month) Jan. (Day) 9 (Year) 19 57			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Single	Sept. 27, 1913	43 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Clerk		Retail Grocery		Cumberland, Md.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph M. Weber				Anna M. Lueck			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		214-05-6384		Mr. Joseph M. Weber, Cumberland, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Thrombosis						1 hr.	
ANTECEDENT CAUSE(S) DUE TO (B) Acute myocardial infarction						1 hr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Hypertensive heart disease						4 yr.	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
none						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
				none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
none		White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from Nov. 27, 1957 to Jan. 9, 1957 , that I last saw the deceased alive on Jan. 9, 1957 , and that death occurred at 1:25 PM , from the causes and on the date stated above.							
SIGNATURE J. F. Scarielli M.D.				DATE SIGNED 1/11/57			
ADDRESS (Street, city, town, state) M.D. 140 Bedford St., Cumberland, Md.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-12-57		SS. Peter & Paul		Cumberland, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Jan. 14, 1957		W. L. Gandy M.D.		James F. Scarielli, Cumberland, Md.			

INSTRUCTIONS

TO A ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. The bottom copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U. S. A.

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>184 E. Main</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J.</u> Last <u>Workman</u>		4. DATE OF DEATH Month <u>I</u> Day <u>8</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6 1906</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Frostburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Verus Workman</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Keller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Anna Workman, Wife 193 W. Main St.</u>		Address <u>Frostburg, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Massive Coronary Occlusion</u> DUE TO (b) <u>1 minute?</u> DUE TO (c) <u>1 minute?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypertensive Heart Disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED <u>White</u> <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 16, 1956</u> to <u>JAN. 8, 1957</u> that I last saw the deceased alive on <u>JAN. 7, 1957</u> , and that death occurred at <u>9:22 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Martin M. Rothstein M.D.</u>		ADDRESS (Street, city or town, state) <u>48 Broadway</u>	
PHYSICIAN'S NAME (Type) <u>MARTIN M. ROTHSTEIN M.D.</u>		DATE SIGNED <u>1/10/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>I-II-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benah H. Winters</u>		ADDRESS <u>23 E. Main, Frostburg</u>	
24a. REC'D BY REGISTRAR <u>Jan 11 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy N. De</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON ONE 18

BUREAU V. S.

JAN 14 1957

RECEIVED

69 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 15 19 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 502 PARK STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle L. Last ZAIS		4. DATE OF DEATH Month JAN. Day 21 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 26, 1902
9. AGE (In years less birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARMAN		10b. KIND OF BUSINESS OR INDUSTRY B&O R.R. CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM L. ZAIS		14. MOTHER'S MAIDEN NAME MARY YOUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8523	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema. 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adeno Carcinoma Lung (Rt) - Cerebral (c) + Skeletal Metastases. INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1956 to 21 Jan 1957 , that I last saw the deceased alive on 21 Jan 1957 , and that death occurred at 8:23 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Fuller B. Whitworth M.D.		ADDRESS (Street, city or town, state) Cumberland Md	
PHYSICIAN'S NAME (Type) FULLER B. WHITWORTH, M.D.		DATE SIGNED 21 Jan 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/24/57	22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery	22d. LOCATION (City, town, or county) (State) Westernport, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Jan 24, 1957		24b. REGISTRAR'S SIGNATURE W.R. Panty, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11. 2004年12月1日，甲企业向乙企业销售一批商品，售价为10000元，增值税税额为1700元，该批商品的成本为6000元。甲企业于2004年12月10日收到乙企业支付的货款，并开具增值税专用发票。甲企业应确认的收入为（ ）元。

25 JAN 25 1957

RECEIVED